NCQA’s Patient-Centered Medical Home
PCMH 2011

Presentation to CalSIM Grantee Staff & Stakeholders
June 5, 2013

We work toward high-value health care

VALUE
Measurement, transparency and accountability move health care toward greater value
What We Know

• All providers should be part of an accountable entity.
  – PCMHs can be aggregated up and benchmarked on cost and quality.
  – Specialists need to be part of the accountable entity too.

• NCQA uses a total population management approach.
  – Addressing healthcare needs on the front end will keep people out of the ER/ambulatory ICUs.

Evolving Delivery Landscape

Health Plans

ACOs

HEDIS & CAHPS

PCMH

Voluntary Performance Measures

Hospital

Specialty Care

Behavioral Health
ACO Accreditation: What Early Adopters are Saying
• “Allowed us to better connect dots for all our departments to streamline work & improve.” Beth Waterman, HealthPartners:
• “Subjecting ourselves to an outside checklist & review made us better.” Doug Carr, MD, Billings Clinic
• “Ensured that we were implementing uniform standards across our four-state health system… helped embed the Triple Aim goals into the fabric of our organization.” John Smylie, Essentia Health
• “Demonstrates to the marketplace that our organization offers better value.” Jonathan Crossette, The Children’s Hospital of Philadelphia

Public/Private Support for PCMH
22 states have Medicaid or multi-payer initiatives using NCQA’s PCMH
• Pay for Performance
  – PCMH payments based on Recognition levels
• Encouraging enrollees to get PCMH care
  – Lower cost sharing for PCMHs
  – Educate enrollees on PCMH benefits
  – Feature PCMHs in provider directories
• Sponsoring practices to become PCMH
  – Cover Recognition costs/offer technical assistance
• ACA Sec. 2703 Health Home SPAs – 4 states list NCQA
Federal Support for PCMH

- **HRSA Patient-Centered Medical Health Home Initiative**
  - Focus on Community Health Centers - serve rural, underserved, often nurse-led practices
  - Covers Recognition costs and technical assistance
  - Up to 500 Community Health Centers per year; 5 year contract
  - 388 Recognized sites to date with 53 of those in CA. In CA we have issued 266 total tools

- **CMS Advanced Primary Care Practice Demonstration**
  - Federally Qualified Health Centers (FQHCs)
  - 500 FQHCs in 3-year project
  - Track progress toward being a Medical Home
  - CMS reimburses for managing Medicare beneficiaries
  - Goal: 90% achieve Level 3; 64 sites Recognized to date, 50 at Level 3.

PCMH Federal Support con’d

- **Military Health System - Military Treatment Facilities (MTF)**
  - Initially a PCMH self-assessment initially; then Recognition
  - Minimum 50 per year over 5 years.
  - 172 sites Recognized to date.
  - Includes: Internal Medicine, Family Practice, Pediatrics

- **HIT/MU – CMS pays practices who demonstrate Meaningful Use; PCMH increases value to practices to become recognized**

- **ACA Sec. 2703 Health Home – 8 quarters of 90% match**
Sampling of Initiatives in States Using NCQA PCMH

<table>
<thead>
<tr>
<th>State</th>
<th>Initiative</th>
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<tbody>
<tr>
<td>Colorado</td>
<td>HealthTeamWorks Multi-payer Pilot (CPCI); Multi-payer Advanced PCP Demo</td>
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<tr>
<td>Connecticut</td>
<td>Connecticut Primary Care “Glide Path” Program</td>
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<tr>
<td>Delaware</td>
<td>Medical Society of Delaware PCMH Initiative (Highmark)</td>
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<tr>
<td>Florida</td>
<td>Medicaid Medical Home Task Force (endorsing NCQA – still pending w/ current support: BCBSFL, MDVIP)</td>
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<tr>
<td>Georgia</td>
<td>Georgia AFP and Pediatric Health Improvement Coalition (PHIC)</td>
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<tr>
<td>Kansas</td>
<td>Kansas AFP PCMH Initiative (Kansas Health Foundation, Pfizer, Sunflower, BCBS of KS)</td>
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<tr>
<td>Kentucky</td>
<td>Greater Louisville Medical Society</td>
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<tr>
<td>Louisiana</td>
<td>DHH -Louisiana Health Care Quality Forum, LPCA</td>
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<tr>
<td>Maine</td>
<td>Patient Centered Medical Home Pilot</td>
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<tr>
<td>Maryland</td>
<td>Maryland Health Care Collaborative (MHCC) +1 Model</td>
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<tr>
<td>Massachusetts</td>
<td>State Medicaid PCMH Initiative/MassGen: Partners Healthcare</td>
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<tr>
<td>Missouri</td>
<td>Missouri Medical Home Collaborative (Wellpoint &amp; UHC)</td>
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<tr>
<td>Montana</td>
<td>PCMH Montana Project</td>
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<tr>
<td>New Jersey</td>
<td>NJ Medicaid Medical Home Pilot (NJAFP)</td>
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<tr>
<td>New York</td>
<td>State Medicaid, PCP; NYS Health Foundation; NYS Hospital Medical Home Demo</td>
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<tr>
<td>North Carolina</td>
<td>Community Care of North Carolina (N3CN)/BCBS of NC</td>
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<tr>
<td>Ohio</td>
<td>PCMH Education Pilot Project</td>
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<tr>
<td>Oregon</td>
<td>Patient Centered Primary Care Home (PCPCH) +1 Model</td>
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<tr>
<td>Pennsylvania</td>
<td>Chronic Care Initiative, Phase II includes Medicare</td>
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<tr>
<td>Rhode Island</td>
<td>Chronic Care Sustainability Initiative (CSI-RI)</td>
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<tr>
<td>South Carolina</td>
<td>South Carolina Department of HHS (BCBS of SC)</td>
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<tr>
<td>Texas</td>
<td>Texas Medicaid/CHIP in progress</td>
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<tr>
<td>Washington</td>
<td>State Medicaid Medical Home Initiatives – Reviewing NCQA PCMH Recognition Programs</td>
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<tr>
<td>Vermont</td>
<td>“Blueprint for Health”</td>
</tr>
<tr>
<td>Wyoming</td>
<td>Wyoming Health Care Innovation Award (DOH, CMS, Transformed)</td>
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As of 06/03/13

Commercial PCMH Pilots
Initiatives Strong, Some Expanding

- WellPoint participating in NH, CO and NY multi-payer pilots demonstrated savings and improved quality, expanding PCMH nationwide

- Horizon Blue Cross Blue Shield of NJ – Lower admissions, readmissions, and ER visits, improved care for chronic disease (diabetes)

- Aetna launched PCMH initiatives in CT and NJ, also plans to expand PCMH nationwide

- Cigna’s Collaborative Accountable Care program shows improved quality, lower Costs
NCQA Patient-Centered Medical Homes

*As of 4/30/13

NCQA PCMH Activity in California

• Plan & Provider Initiatives:
  - LA Care, Pilot supporting practice transformation.
  - California Primary Care Association launched a Patient-Centered Health Home (PCHH) initiative in 2012.

• Adoption in California:

<table>
<thead>
<tr>
<th>Model Type</th>
<th>Sites</th>
<th># of Clinicians</th>
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<tbody>
<tr>
<td>Military</td>
<td>13</td>
<td>23</td>
</tr>
<tr>
<td>IPA</td>
<td>21</td>
<td>146</td>
</tr>
<tr>
<td>Medical Group</td>
<td>94</td>
<td>638</td>
</tr>
<tr>
<td>Total</td>
<td>128</td>
<td>807</td>
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**PCMH 1: Enhance Access and Continuity**

**Intent of Standard**
- Patients have access to routine/urgent care and clinical advice during/after hours that are culturally and linguistically appropriate
- Electronic access
- Clinician selected by patient
- Team-based care; trained staff

**Elements**
A. Access During Office Hours
B. After-Hours Access
C. Electronic Access
D. Continuity
E. Medical Home Responsibilities
F. Culturally and Linguistically Appropriate Services
G. The Practice Team

**Access During Office Hours is a Must Pass Element**

**Critical Factors:**
- Providing same-day appointments
- Providing timely advice when the office is closed
- The practice team has regular team meetings or a structured communication process

**PCMH 2: Identify/Manage Patient Populations**

**Intent of Standard**
- Collects demographic and clinical data for population management
- Assess/document risks
- Create lists; use for point of care reminders

**Elements**
A. Patient Information
B. Clinical Data
C. Comprehensive Health Assessment
D. Use Data for Population Management

**Use of Data for Population Management is a Must Pass Element**

The practice must identify patients in at least 2 of 4 areas of need and provide proactive outreach to remind patients/families about:
- Preventive services
- Chronic care services
- Being overlooked or not seen recently
- On specific medications
PCMH 3: Plan and Manage Care

Intent of Standard
- Identify patients with specific conditions including high-risk or complex, behavioral health
- Care management
  - Pre-visit planning
  - Progress toward goals
  - Barriers to treatment goals
- Reconcile medications
- E-prescribing

Elements
A. Implement Evidence-Based Guidelines
B. Identify High-Risk Patients
C. Care Management
D. Medication Management
E. Electronic Prescribing

Care Management is a Must Pass Element

Critical Factors:
- Implement evidence-based guidelines for a condition related to unhealthy behaviors or mental health or substance abuse
- Reviews and reconciles medications with families/families for more than 50% of care transitions
- Generate at least 75% of eligible prescriptions electronically

PCMH 4: Provide Self-Care/Community Resources

Intent of Standard
- Assess self-management abilities
- Document self-care plan; provide tools and resources
- Counsel on healthy behaviors
- Assess/provide/arrange for mental health/substance abuse treatment
- Provide community resources

Elements
A. Supports Self-Care Process
B. Provides Referrals to Community Resources

Supports Self-Care Process is a Must Pass Element

Critical Factor:
- Develops and documents self-management plans and goals in collaboration with at least 50% of patient/families
PCMH 5: Track and Coordinate Care

Intent of Standard
- Tracks, follows-up on and coordinates tests, referrals and patient care in other facilities.
- Establish information exchange with facilities.
- Follows up with discharged patients.

Elements
A. Track Tests and Follow-Up
B. Track Referrals and Follow-Up
C. Coordinate with Facilities/Care Transitions

Referral Tracking and Follow-Up is a Must Pass Element

Critical Factors:
- Tracks lab tests and imaging tests until results are available, flagging and following up on overdue results.

PCMH 6: Measure and Improve Performance

Intent of Standard
- Practice uses performance and patient experience data to continuously improve.
- Track utilization measures.
- Identifies vulnerable populations.

Elements
A. Measure Performance
B. Measure Patient/Family Experience
C. Implements Continuous Quality Improvement
D. Demonstrates Continuous Quality Improvement
E. Report Performance
F. Report Data Externally
G. Use of Certified EHR Technology

Implements Continuous Quality Improvement is a Must Pass Element

Practice can achieve Distinction by using CAHPS PCMH to collect and submit patient experience data.
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Additional Background

• PCMH Development
• PCMH Evidence of Success
• Meaningful Use and PCMH
• Patient-Centered Specialty Practice Recognition (PCSP)
• CLAS embedded in PCMH and PCSP
The Triple Aim

- A framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to health system performance
- The three dimensions are:
  - Improving the patient experience of care (including quality and satisfaction)
  - Improving the health of populations
  - Reducing the per capita cost of health care
- These three key concepts are embedded throughout the NCQA PCMH requirements

PCMH Development History

- Systematic approach to delivering preventive and chronic care (Wagner Chronic Care Model)
- Built on IOM’s recommendation to shift from “blaming” individual clinicians to improving systems
- Measures actionable for practices
- Validate measures by relating them to clinical performance and patient experience results
- PPC-PCMH incorporated Joint Principles:
  - Whole-person focus
  - Coordinated, integrated, comprehensive care
  - Personal clinician, team-based care
Growing Evidence on PCMH

• Significant improvement in ratings of access to care
  L. M. Kern, R. V. Dhoshewarkar, A. Edwards et al., American Journal of Managed Care, May 2013

• Benefits of Implementing the PCMH – Improved Quality & Patient Satisfaction, Lower Costs
  Patient Centered Primary Care Collaborative, September 2012

• Colorado PCMH Multi-Payer Pilot Reduced Inpatient Admissions, ER Visits & Demonstrated Plan ROI
  Harbrecht, Health Affairs, September 2012

• PCMH Improves Low-income Access, Reduces Inequities
  Berenson, Commonwealth Fund, May 2012

• Better Preventive Health, Disease Management, Lower Resource Use & Costs
  DeVries, American Journal of Managed Care, September 2012

Research Continued:

• Patient-Centered medical home cost reductions for complex patients (Flottemesch TJ, Anderson LH, Solberg LI, Fontaine P, Asche SE., 2012)

• Medicaid Pilots: Improved access to care, reduced PMPM/PMPY costs, decreased ER and inpatient utilization, greater use of evidence-based primary care (Takah, 2011)

• Higher quality of care, reduced cost of care on some measures (Patient-Centered Primary Care Collaborative, 2010)

• Reduced hospitalization and ER visits, overall savings (Fields, Leshen, Patel, 2010)

• In integrated group practice, improvements in quality of clinical care, patient and provider experiences (Reid, 2009)
Medicaid PCMH Pilots
Early Results Promising

• Oklahoma (Medicaid-wide): $29 reduced per patient per year costs, increased access, increased use of evidence-based primary care, increased patient satisfaction

• Colorado (Medicaid and CHIP): Large increase in access and patient satisfaction, decreased per patient per year costs

• Vermont (Blueprint for Health): Decreased inpatient and ER utilization, decreased PMPM costs

• North Carolina Medicaid (Community Care): Over $1 billion in total savings

Takach, Health Affairs, July 2011 (1325-1334) / Milliman Analysis

Meaningful Use of Health Information Technology (HIT)

• NCQA emphasizes HIT because good primary care is information-intensive

• PCMH 2011 reinforces incentives to use HIT to improve quality

• Meaningful Use language is embedded, often verbatim, in PCMH 2011 evaluation standards

• Synergy/virtuous cycle: PCMH 2011 medical practices will be well prepared to qualify for meaningful use, and vice versa
Patient-Centered Specialty Practice Recognition

- New complimentary PCMH-like program for specialty practices meeting rigorous & practical standards for coordinating with primary care, such as:
  - Timely access to care
  - Consultation with primary care providers
  - Managing care for individuals and population
  - Coordination with facilities on care transitions and post-discharge follow-up

- Launched March 2013
- 73 early adopter organizations across 28 states

Patient-Centered Specialty Practice (PCSP) Recognition Value & Uses

- Activates American College of Physicians’ “Medical Neighborhood”
- Distinguishes practices committed to coordinating care, reducing waste
- Shows readiness for PCP referrals & ACOs
- States can promote PCSP by:
  - Building in care coordination payments
  - Highlighting on provider directories
  - Using as a quality indicator in value-based purchasing (preferred tier” with lower copay)
<table>
<thead>
<tr>
<th>CLAS Built into both Medical and Specialty Care Recognition Programs</th>
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<tbody>
<tr>
<td>• Provides CLAS appropriate services</td>
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<tr>
<td>• Trains the practice team to adequately support patients</td>
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<tr>
<td>• Maintains electronic tracking system to capture race, ethnicity and preferred language</td>
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<tr>
<td>• Conducts comprehensive assessment including cultural characteristics &amp; communication needs</td>
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<tr>
<td>• Tracks key community resources</td>
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<tr>
<td>• Monitors performance to assess disparities in care &amp; sets a QI goal</td>
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<td>• Collects feedback on experience of vulnerable populations</td>
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